Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-09-5799-01
J. THOMAS DILGER, JR., M.D. 6718 MONTAY BAY DRIVE SPRING, TX 77389	
Respondent Name and Box #: AMERICAN HOME ASSURANCE CO BOX # 19	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

The Requestor did not submit a position summary.

Principle Documentation:

1. DWC 60 package
2. Medical Bill(s)
3. EOB(s) – not submitted
4. Medical Reports
5. Total Amount Sought $1125.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary states in part…"No reimbursement was made for the $1, 1225.00 {sic} amount charged as the bill was not received timely as required by the WC Statute. We received the bill 1/26/09. I previously sent you the EOB showing we received the bill 01/26/09. Our file contains a report that was faxed from the DWC to us on 8/24/07. There was no bill attached to the DWC fax. I also sent you the cover sheet and the first page of the report. The Carrier has no evidence showing that the bill for services was submitted timely; therefore you {sic} ask that you find that the Requestor is due no reimbursement for this date of service…."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
8/9/07	NO EOB'S SUBMITTED	99456-WP, 99456-RE, 96118	$1125.00	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

1. Medical Fee Dispute Resolution (MFDR) received the DWC-60 on 1/28/09. The date of service in dispute is 8/9/07.
2. 28 TAC Section 133.307(c)(1)(A) states in part, "A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."
3. This dispute was not submitted timely.
4. The Division concludes that this dispute was not filed in the form and manner prescribed under Rule 133.307 section (c)(l)(A). As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code Sec. §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

		12/7/09
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.